MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Has there been any change in your general health within the past year? ❒ Yes ❒ No
   Please specify _____
2. Are you under the care of a physician for a current problem? ❒ Yes ❒ No
   Reason _____
3. Have you been hospitalized with the past five years? ❒ Yes ❒ No
   Reason _____
4. Are you taking any medications or drugs? ❒ Yes ❒ No
   Please specify _____
5. Have you received therapy for alcoholism or drug addiction during the past five years? ❒ Yes ❒ No
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, or other medications? ❒ Yes ❒ No
   Please specify _____
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma? ❒ Yes ❒ No
8. Have you ever required a blood transfusion?
   Please explain _____ ❒ Yes ❒ No
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition? ❒ Yes ❒ No
10. Have you ever been tested for HIV infection (AIDS)? ❒ Yes ❒ No
    Result of test: ❒ Positive ❒ Negative Date _____
11. Date of last physical exam _____
12. Do you have or have you had any of the following (please check):
    - ❒ High blood pressure
    - ❒ Heart murmur of prolapsed valve (MVP)
    - ❒ Joint prosthesis (hip, knee, etc.)
    - ❒ Rheumatic fever or rheumatic heart disease
    - ❒ Congenital heart disease
    - ❒ Cardiovascular disease: heart attack, stroke, by-pass
    - ❒ Prosthetic heart valve
    - ❒ Blood disorder (e.g., anemia)
    - ❒ Venereal disease
    - ❒ Asthma
    - ❒ Temporomandibular joint problems (TMJ)
    - ❒ Thyroid problems
    - ❒ Diabetes
    - ❒ Stomach ulcers, colitis
    - ❒ Hepatitis, jaundice, liver disease
    - ❒ Kidney problems
    - ❒ Psychiatric treatment
    - ❒ Fainting spells or seizures
    - ❒ Epilepsy
    - ❒ Cancer
    - ❒ Sinus trouble
13. Do you have any disease, condition, or problem not listed above? ❒ Yes ❒ No
    Please specify _____
14. Are you required to take premeds prior to dental treatment? ❒ Yes ❒ No

Women:

15. Are you pregnant? ❒ Yes ❒ No
16. Are you nursing? ❒ Yes ❒ No
17. Do you take birth control pills? ❒ Yes ❒ No
    If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT: I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Signature of Patient* _____ Date _____

**All signatures must be by parent or guardian if patient is under the age of 18.*